A Healthier Tomorrow Starts Today!

Why Read This Handbook?

This Handbook provides information about health insurance available through the Healthy Families Program.

This Handbook has the information about the health, dental and vision plans available in your county.

The application for the insurance is a separate form. To receive an application form, ***call toll-free 1-888-747-1222***, 9 a.m. to 6 p.m., Monday-Friday.

Keep this Handbook and the application instructions for future reference.

Please read the following sections carefully:

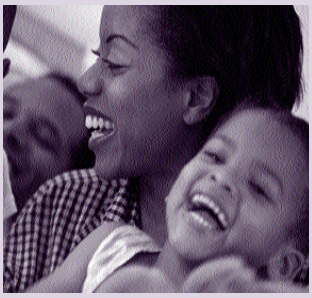
- Eligibility (page 3)
- Enrollment (page 5)
- Insurance Premiums (page 7)
- Summary of Benefits (page 11)
- Selecting Insurance Plans (page 18)

If you want to complete the application, you may either:

1. Complete the application yourself in the privacy of your home; *or*
2. ***Call toll-free 1-800-880-5305,*** 8 a.m. to 8 p.m., Monday-Friday, and Saturday from 8 a.m. to 5 p.m. Call this number to:
   - Get help in filling out the application,
   - Get answers to your questions about the Healthy Families Program,
   - Get information on doctors, clinics, and dentists in your area that are part of the Healthy Families Program,
   - Check the status of an application.

Contents

NOTE: If you are an 18-year-old (or minor living on your own) applying for insurance for yourself, each time this Handbook says "you" or "your family" or "member," it means you.



What is the Healthy Families Program?

The Healthy Families Program is low cost insurance that provides health, dental and vision coverage to children who do not have insurance today and do not qualify for no-cost Medi-Cal.

How will the Program provide health care for my children?

When you enroll your children in the Program, you choose the health, dental and vision insurance plans. The plans provide the health, dental and vision coverage for your children. This insurance pays most of your children's costs for visits to doctors, dentists, and specialists. The insurance plans also contract with clinics, laboratories, pharmacies and hospitals for your children's health care.

Who can help me fill out the application?

If you need help to complete the application or have questions, ***call toll-free, 1-800-880-5305***, 8 a.m. to 8 p.m., Monday through Friday, and Saturday from 8 a.m. to 5 p.m.

You can visit our Web site at ***www.healthyfamilies.ca.gov***

Eligibility

Who may qualify?

- Children up to their 19th birthday.
- Children in families with incomes at or below 250% of Federal Income Guidelines.
- Children in the family without employer-sponsored health insurance in the last three months.
- Children living in California.
- Children who are not eligible for no-cost Medi-Cal.
- Children who meet citizenship/immigration requirements.

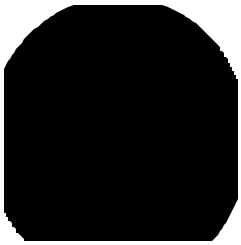
Newborns and children under one year old may qualify for Healthy Families if the family meets the income requirements. See page 2 of the Application for income requirements for children under one year of age.

Who can apply?

Parents, legal guardians, stepparents, foster parents or caretaker relatives may apply for insurance for a child living in their home. **Only the parents' income will be considered.** If you are a legal guardian, stepparent, foster parent or caretaker relative who lives with a child, your income will not be used to qualify the child for the Program.

If you are age 18 or under, you may qualify to apply for your own insurance if you meet the income requirements.

Minors who do not live with parents, legal guardians, stepparents, foster parents or caretaker relatives may be eligible for the Program for themselves or their children if they meet all other requirements.



Eligibility

How do I determine my family's income?

The application form has information on how to determine your family's monthly income, and the type of documentation required as proof of income.

Does my child qualify?

To see if your child qualifies, refer to the Healthy Families application form ***or call toll-free, 1-800-880-5305***.

What if my child currently has insurance?

If anyone in your family is covered today by an employer-sponsored health insurance plan, that person is not eligible for Healthy Families. If your child has had employer-sponsored insurance in the last three months, the child is not eligible for Healthy Families coverage.

If the insurance coverage through an employer ends, the child may be eligible for the Healthy Families Program if:

- The person or parent providing health coverage lost a job or changed jobs; ***or***
- The family moved into an area where employer-sponsored coverage is not available; ***or***
- The employer discontinued health benefits to all employees; ***or***
- Coverage was lost because the individual providing the coverage died, legally separated, or divorced; ***or***
- Health coverage was provided under a federal Consolidated Omnibus Budget Reconciliation Act (COBRA) policy, and the COBRA coverage ended; ***or***
- The person reached the maximum coverage of benefits allowed in the current insurance in which the person is enrolled.

Enrollment

How do I apply for Healthy Families?

Fill out the application form and mail it in the envelope provided. A complete application should have all the information requested and copies of all required documents attached. Be sure to include your first month's premium.

If you need help filling out your application, ***call toll-free 1-800-880-5305***. You can call between 8 a.m. and 8 p.m., Monday through Friday, and Saturday from 8 a.m. to 5 p.m. The Healthy Families Program Representative can answer your questions.

How long will it take to process my child's application?

When we receive a complete application, Healthy Families will process it within 10 calendar days to determine eligibility. You will be notified by letter and will also receive a welcome telephone call. The letter gives the date on which insurance coverage will begin for each enrolled child. The first day of coverage begins 10 days from the date Healthy Families determines that a child qualifies for the Program.

If your application is not complete, we will notify you in writing. We will also try to reach you by phone. You must submit all requested information by the due date indicated in the letter. The Program will not be able to determine eligibility in a timely manner if you do not send in the information requested. You will have to reapply (send in a new application) if the requested information is not received within 60 days from the date that the first application was received.

If your income is below the Healthy Families requirements, and you did **not** check the ***"I DO NOT WANT Medi-Cal"*** box on the application, your application will be forwarded to the Department of Social Services in your county. They will contact you within 45 days to inform you of your family's Medi-Cal eligibility.

If you believe we made a mistake in deciding whether your child is eligible, you can request a review. See the *Appeals* section on *page 32* of this Handbook, ***or call toll-free, 1-800-880-5305***.

Enrollment

If I am pregnant, and the baby will not have insurance once born, can I apply for Healthy Families before the baby is born?

You can apply for insurance up to three months before a baby is born. Please fill out an application and send in the documentation required. You will also need to send a copy of a pregnancy certificate that shows the estimated date of delivery to determine the baby's eligibility. If eligible, you will be notified in writing.

Within 30 days of the baby's birth, you must send in a copy of a certificate of birth provided by the hospital or other health care facility, a signed statement by the health practitioner who delivered the baby, or an equivalent document. Insurance coverage for the baby will begin 13 days from the date this additional information is received.

If within 30 days of the baby's birth, Healthy Families does not receive a copy of the birth certificate or proof of birth, your case will be closed. You will need to reapply and provide all necessary documentation with your new application.

If my child's Medi-Cal coverage is ending, how soon can I apply for Healthy Families?

You can apply for Healthy Families up to three months in advance if one of the following is going to occur:

- A child turns ***one year old*** and loses no-cost Medi-Cal (Healthy Families coverage begins the first of the month after the child's first birthday); ***or***
- A child turns ***six years old*** and loses no-cost Medi-Cal (Healthy Families coverage begins the first of the month after the child's sixth birthday); ***or***
- A child's no-cost Medi-Cal ends.

To find out the status of your application, ***call toll-free 1-800-880-5305***, 8 a.m. to 8 p.m., Monday through Friday, and Saturday from 8 a.m. to 5 p.m.

Insurance Premiums

How much does it cost to cover my family?

The monthly premium for children is determined by income category, which includes family size, family income, and the health plan you choose. You pay a monthly premium between $4 and $9 for each child, up to a maximum of $27 for all children in a family enrolled in the Healthy Families Program.

The *Insurance Plans by County and Premium* section begins on *page 43* of this Handbook. This section shows how much the monthly premium for the insurance coverage will cost you. The premium amount listed under Category A and B includes the dental and vision coverage. You can determine which category (A or B) your monthly income falls under by following the instructions on *page 36.* Then you can determine the monthly premium when you choose the health insurance plan for your child. All children in the household must be enrolled in the same plans.

If the applicant or child applying to the Healthy Families Program is of American Indian descent or Alaska Native, the premium payments and co-payments may be waived. To waive premiums and co-payments, American Indian descendants or Alaska Natives must submit one of the following acceptable documents as proof of ancestry:

- Copy of an American Indian or Alaska Native enrollment document from a federally recognized tribe; **or**
- A Certificate of Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs; **or**
- A letter of Indian Heritage from an Indian Health Service supported facility operating in the State of California.

Insurance Premiums

What if I don't have proof of American Indian or Alaska Native ancestry?

Persons or families who claim American Indian or Alaska Native ancestry will have two months from the date of enrollment to provide acceptable proof. Healthy Families will waive premiums for two months, but co-payments will not be waived until the documents are received and approved.

The premium and co-payments will be waived the month after Healthy Families receives acceptable documentation. Healthy Families will not refund co-payments paid during the months when we had no acceptable proof of your ancestry.

How do I pay my monthly insurance premiums?

Mail the first month's premium payment with your application. Make your payment to the **Healthy Families Program**.

Once your child is enrolled in Healthy Families, you will receive a statement in the mail each month. **Your payment will be due on the 20th day of the month.** Your payment will be considered late when received after the 20th of the month.

You can pay your monthly premium by:

- **Personal check**
- **Cashier's check**
- **Money order**
- **Credit card**
- **Cash**

You may pay in cash at a Rite Aid store. ***Call toll-free at 1-800-748-3243*** for the Rite Aid store nearest you.

- **Electronic Fund Transfer (EFT)**

  An EFT allows your monthly premium to be automatically withdrawn from a savings or checking bank account and deposited into the Healthy Families Program account each month.

  The bank account can be your own personal account ***or*** of someone else. **You will receive a 25% discount on your monthly premium if you pay by EFT**.

  You may request the best payment option for yourself when you receive your first statement. The information on EFT payments is on the reverse side of your Healthy Families billing statement. For more information about EFT, ***call 1-866-848-9166***.

Insurance Premiums

Can I save money on my premiums?

Yes. If you pay in advance for three consecutive months of premiums, you get free coverage the fourth month. To earn a free month of coverage, your three-month payment must be received before the 20th of the month. ***This option is not available if you pay by EFT.*** If you sign up to pay by EFT, you will receive a 25% discount on your monthly premium.

You can also save money by choosing the "Community Provider Plan" in your area. This insurance plan has done the best job of including the providers in your area who have traditionally served uninsured persons in your community. To reward the insurance plan for its commitment to your community, we offer the insurance plan to you at a discount. The premium listed includes a $3 discount per person. These plans are shown in the *Insurance Plans by County and Premium* section, starting on *page 43* of this Handbook.

What if I do not pay my monthly insurance premiums?

If you do not make premium payments for two consecutive months, your child will be disenrolled. If your child is disenrolled for non-payment, the coverage will end at the end of the second consecutive month for which you did not make a premium payment. Healthy Families will send reminder notices before the disenrollment occurs. You will be responsible for the cost of any health care received by your child after coverage ends.

Insurance Premiums

How are payments applied to my family's account?

Payments or credits on your account will first be applied to the child's past due account.

Any money left is applied to the child's premium for the current month.

If after paying for the child's premiums for the current month there is enough money left, it will be applied towards three months of premiums for the child, and one month of free coverage for the child will be earned.

What if I do not receive a billing statement?

It is the applicant's responsibility to send in payments. All payments are due by the 20th of the month. **Write your Family Member Number on the check or money order, and send it to:**

Healthy Families Program
Payment Section
P.O. Box 24480
Oakland, CA 94623-1480

Remember: Send only your payments to this address. Please do not send any correspondence to this address.

NOTE: To earn a free month of coverage, your three-month payment must be received before the 20th of the month in which it is due.

Summary of Benefits

The Healthy Families Program offers comprehensive health, dental and vision coverage through insurance plans. The benefits in all Healthy Families' insurance plans are similar. The benefits may be administered differently.

Enrolled children are eligible for all covered services that are medically necessary. Healthy Families will not deny coverage based on a person's health condition. You will be notified of the date that your child can begin receiving services.

See the charts on *pages 14-17* of this Handbook for a summary of benefits and services offered by each health plan.

Is there an additional cost for my child to get these services?

Yes. In addition to the monthly premiums, you pay a co-payment of $5 at the time of services for children's benefits. Some services are free. No individual charge will exceed $5 for children's benefits.

The **maximum** co-payment amount per benefit year that you pay for health care services is $250 per family. **A benefit year** is from July 1 to June 30. **Keep all your receipts for the co-payments you make at the time of receiving health care services.** Let your health plan know if you reach the maximum $250 for the benefit year of coverage. Then you will not have to make any more $5 co-payments for health care services until the next benefit year of coverage.

You can visit our Web site at
www.healthyfamilies.ca.gov

Summary of Benefits

Pregnancy

Pregnant members of the Healthy Families Program may qualify for no-cost Medi-Cal coverage for their pregnancy-related services. The baby will be insured by no-cost Medi-Cal for the first year. For information on no-cost Medi-Cal, call your local County Department of Social Services, a local Medi-Cal provider, or ***call 1-866-848-9166***.

Healthy Families members are eligible for pregnancy-related services under the Program. To enroll the baby in the Program, you must send in an "Add a Person Form" within 30 days of birth. If the baby is not eligible for Healthy Families and you did not check the **"I DO NOT WANT Medi-Cal"** box, the application will be forwarded to the County Department of Social Services to determine Medi-Cal eligibility.

California Children's Services

The California Children's Services (CCS) program provides health care and case management for persons under 21 years of age with certain medically handicapping conditions. If a provider suspects that an eligible condition exists, a referral will be made to the local CCS Program in your county.

CCS will determine if a member has an eligible condition. CCS will provide all treatment and services for that condition. The member will remain enrolled in the Healthy Families Program for all other health care.

If a member already receives services from CCS, contact your health care provider when you enroll that person in the Healthy Families Program.

Your insurance plan and provider will arrange for care with CCS. If you have any questions about CCS, talk to your family's health care provider.

Summary of Benefits

Mental Health

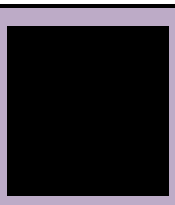
Children enrolled in the Healthy Families Program receive mental health services through two delivery systems:

Local County Department of Mental Health
Children needing specialized mental health services for a Serious Emotional Disturbances (SED) condition may receive care from their local county department of mental health.

Health Plan
Children receive basic mental health services through participating health plans.

If your child's provider suspects that a SED condition exists, your child will be referred to the county mental health department for assessment and treatment. Your child will remain enrolled in the health plan and will continue to receive all other medically necessary care from the Healthy Families Program not related to the SED condition.

If your child already receives services from the local county department of mental health, please contact your health providers after you have enrolled in the Healthy Families Program. Your health plan and provider will coordinate care with the local county mental health department. If you have questions about mental health services, talk to your child's health provider.



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www.healthyfamilies.ca.gov

Summary of Benefits

Benefits *	Services	Costs to Member (co-payment)
Physician Services	◆ Office, home visits ◆ Allergy testing and treatment	◆ $5 per visit ◆ $5 per visit
Preventive Care	◆ Periodic health examinations (including well-baby care) ◆ Variety of voluntary family planning services ◆ Prenatal care ◆ Vision and hearing testing ◆ Immunizations ◆ Venereal disease tests ◆ Confidential HIV/AIDS counseling and testing ◆ Annual Pap smear exams ◆ Health education services	◆ No charge (including office visits)
Prescription Drugs	◆ 30-34 day supply of brand name or generic drugs, including prescriptions for one cycle of tobacco cessation drugs ◆ 90-100 day supply of maintenance drugs ◆ While in hospital ◆ FDA approved contraceptive drugs and devices	◆ $5 per prescription ◆ $5 per prescription ◆ No charge ◆ No charge
Hospital	◆ Inpatient care	◆ No charge
Emergency Health Care Services	◆ 24-hour emergency for illness, injury, or severe pain requiring immediate diagnosis and treatment to avoid placing the subscriber in danger of loss of life, serious illness, or disability ◆ Provided both in and out of the health plan's service area and participating facilities	◆ $5 per visit unless hospitalized No coverage will be provided if the services received are not an emergency
Maternity	◆ Prenatal and postnatal care, inpatient and newborn nursery care	◆ No charge
Medical Transportation	◆ Emergency medical transportation	◆ No charge

* Benefits are provided if the insurance plan determines them to be medically necessary.

Summary of Benefits

Benefits *	Services	Costs to Member (co-payment)
Diagnostic X-ray and Laboratory Services	◆ Inpatient and outpatient	◆ No charge
Durable Medical Equipment	◆ Medical equipment appropriate for use in the home, oxygen and oxygen equipment, insulin pumps and all related necessary supplies	◆ No charge
Mental Health**	◆ Diagnosis and treatment of mental illness. Outpatient and inpatient services are provided without limit for serious mental illnesses. All non-serious mental illnesses are limited to 20 outpatient and 30 inpatient hospital services	◆ No charge for inpatient services ◆ $5 per visit for outpatient services
Alcohol and Drug Abuse	◆ *Inpatient:* As medically appropriate to remove toxic substances from the system ◆ *Outpatient:* 20 visits per benefit year (Some plans may choose to increase the number of visits in a benefit year if outpatient services are determined medically necessary)	◆ No charge for inpatient services ◆ $5 per visit for outpatient services
Physical, Occupational, Speech Therapy	◆ Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home. Plans may require periodic evaluations as long as therapy, which is medically necessary, is provided.	◆ No charge for inpatient services ◆ $5 per visit for outpatient services
Home Health Care	◆ Must be prescribed or directed by the attending physician or other appropriate authority designated by the plan	◆ No charge
Skilled Nursing Care	◆ *Inpatient*: Skilled nursing care: 100 days each benefit year	◆ No charge

* Benefits are provided if the insurance plan determines them to be medically necessary.

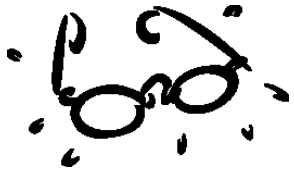
** In addition to these benefits some services are also provided by the California Children's Services (CCS) program and by County Mental Health Departments. Families must meet residential requirements and members under the age of 21 must have a medical condition that is covered by CCS to be eligible for CCS services. Members who are under 19 years of age and diagnosed as having a Serious Emotional Disturbance (SED) will receive services from the County Mental Health Department.

Summary of Benefits

Optional Health Benefits
Not all health insurance plans provide these benefits. See *pages 87-96* of this Handbook for information on which insurance plans cover these services.

Optional Benefits*	Services	Costs to Member (co-payment)
Acupuncture	◆ 20 visits per benefit year	◆ $5 per visit
Chiropractic	◆ 20 visits per benefit year	◆ $5 per visit
Biofeedback	◆ 8 visits per benefit year	◆ $5 per visit
Elective Abortion	◆ Insurance plans vary (see pages 87-96)	◆ No charge

* Benefits are provided if the insurance plan determines them to be medically necessary.



Summary of Benefits

Vision Benefits

Vision Benefits*	Services	Costs to Member (co-payment)
Eye Examinations	◆ Once every 12 months	◆ $5 per examination
Prescription Glasses	◆ Once every 12 months	◆ $5 per glasses, frames, or lenses

Dental Benefits

Dental Benefits*	Services	Costs to Member (co-payment)
Preventive Care (Teeth Cleanings, Topical Fluoride)	◆ Every 6 months	◆ No charge
Fillings	◆ As needed	◆ No charge
Sealants	◆ As needed only for permanent 1st and 2nd molars	◆ No charge
Diagnostic Services	◆ X-rays (Bitewing, Full-mouth, and Panoramic) ◆ Consultations	◆ No charge
Major Services	◆ Root canals ◆ Oral surgery ◆ Crowns and bridges ◆ Dentures	◆ $5 ◆ $5 ◆ $5 ◆ $5
Orthodontia Services	◆ Provided to subscribers under the age of 21 through the California Children's Services Program (CCS) when condition meets the CCS program criteria	◆ No charge

* Benefits are provided if the insurance plan determines them to be medically necessary.

Note: The Benefits Charts on the preceding pages are only a summary of benefits provided by each health plan in the Healthy Families Program. These summaries are for information only. This is not a contract. For exact terms and conditions of the health care benefits, provisions, exclusions, and limitations for each plan, refer to the Evidence of Coverage booklet or Certificate of Insurance available from each health plan. Call the phone number listed on each health plan's description page.

Selecting Insurance Plans

Healthy Families gives you a choice of health and dental insurance plans. Vision Service Plan (VSP) is the designated vision plan. See the *Insurance Plans by County and Premium* section on *page 43* in this Handbook for more information. You can choose from any insurance plan available in the county where your children live. Occasionally, a plan may reach the maximum number of applicants in a county and will not accept new applicants. All children in one household must be enrolled in the same health, dental, and vision plans.

In general, the benefits are the same in all the Healthy Families plans, but each insurance plan administers its benefits differently. *Pages 87-96* of this Handbook answer questions about each insurance plan. These pages help you to compare and choose the insurance plans that best meet your family's needs. For more information about plan benefits, refer to the plan's Evidence of Coverage (EOC) Booklet. You can request an EOC by calling the insurance plan at the telephone number listed on *pages 125-156*.

How do I choose the best insurance plans for my children?

This is a decision you must make. Here are some ***questions that may help you***:

- **Which insurance plans are available in my county?** See the *Insurance Plans by County and Premium* section beginning on *page 43* of this Handbook.
- **In which insurance plans do my doctor and dentist participate?** You may want to call the doctor or dentist directly. Or call Healthy Families ***toll-free at 1-800-880-5305***, 8 a.m. to 8 p.m., Monday-Friday, and Saturday from 8 a.m. to 5 p.m. for information on doctors or dentists in your area.
- **How do I find out which of the insurance plans I am considering have the best customer service?** You may want to call the insurance plans and talk to them directly. For telephone numbers and information on each insurance plan, see the *Individual Plan Descriptions* section, beginning on *page 125* of this handbook, and review the *Plan Quality Comparison Guide* on *pages 105-122* for information about what families think about their health plan.

Selecting Insurance Plans

Follow these "steps" to make your choice of a health, dental and vision insurance plan:

- Review the insurance plans available in your county, which are listed in the *Insurance Plans by County and Premium* section, beginning on *page 43* of this Handbook.
- Review the individual summaries of the insurance plans available in your county. See the *Individual Plan Descriptions* starting on *page 125* in this Handbook.
- Review the *Plan Quality Comparison Guide* on *pages 105-122* of this Handbook. Then review the *Answers to Commonly Asked Questions* section, starting on *page 87* of this Handbook.
- ***Call toll-free 1-800-880-5305*** to request a list of doctors or dentists by specialty, location, ZIP code, language and gender. Healthy Families will give you a personalized list based on where you live.

If you need more information on the insurance plans, please contact them directly. Each insurance plan in this Handbook has a ***toll-free*** number you can call to get more information. The *Insurance Plan Descriptions* begin on *page 125*.

Special Population Plan

Is there a special plan available if my family is American Indian or if my family moves with my seasonal job?

Yes, there is a special insurance plan we call the "Special Population Plan" under Healthy Families, which offers health, dental and vision coverage for American Indians or families employed in seasonal jobs in agriculture, fishery or forestry. This plan combination is available statewide. The plans participating in the statewide plan combination are Blue Cross EPO, Delta Dental and VSP. This special plan combination allows families to maintain the same insurance plans even if they move around the state due to seasonal jobs.

If you are now or have been a seasonal or migrant worker in the last 24 months, employed in agriculture, forestry or fishery, turn to *page 83* to find the combination code for the county you live in. If you are American Indian, you can also choose this combination even if you are not a migrant or seasonal worker.

Selecting Insurance Plans

How do I choose a Primary Care Physician (PCP) or a Primary Care Dentist (PCD)?

As a Healthy Families participant, you can choose a PCP and a PCD for your family. In many cases, you may continue to see your current doctor/dentist.

Call Healthy Families toll-free at 1-800-880-5305 to request a list of PCPs or PCDs in your area. Check the list to find out if you can keep your current PCP/PCD or to find a doctor/dentist who:

- Speaks your language; ***and***
- Is near to your home and/or easy to get to.

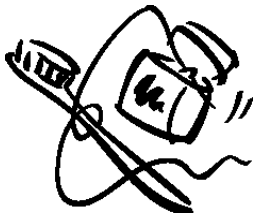
Your children will become members of the insurance plans you choose. Your children's doctor and dentist must be part of the insurance plans you choose.

What if I do not choose a PCP or PCD on my application?

Most health and dental insurance plans require members to have a PCP or PCD. When an insurance plan requires a PCP/PCD to be chosen and you do not choose one on your application, the insurance plan will assign a PCP/PCD for each family member. The insurance plan may call you to assist you in selecting one.

How do I change to a different PCP/PCD?

Each insurance plan has its own rules for how to change and how often a member is allowed to change PCPs/PCDs. See *pages 87-96* in this Handbook for information.



Selecting Insurance Plans

How will my family receive vision benefits?

VSP provides vision insurance to all Healthy Families Program members. When a member needs vision services, eye exams or eyeglasses, ***call VSP at 1-800-877-7239***. VSP will mail you an authorization card. Take the card to one of the providers on the list mailed to you.

Do some of the insurance plans participating in the Healthy Families Program require binding arbitration of health care disputes?

Yes. If you choose one of these insurance plans, you give up the right to a jury or court trial to resolve disputes you may have with your child's insurance plan. See *pages 87-96* of this Handbook to find out which plans use binding arbitration.

Remember: You select your child's plans from the list provided. No one can choose for you.

Citizenship and Immigration Information

What are the citizenship and immigration requirements for the Healthy Families Program?

All persons applying for the Program must be U.S. citizens, U.S. non-citizen nationals, or eligible qualified immigrants. Questions about citizenship and immigration apply to each person applying for the Program.

Who is considered an eligible qualified immigrant?

Following is a list of qualified immigrant statuses and the Immigration and Naturalization Service (INS) documents necessary to prove qualified status.

If the child for whom you are applying for services entered the U.S. **before** or **after** August 22, 1996, the child is eligible to enroll in the Healthy Families Program if all other requirements are met. This change in California State law affects immigration statuses 1 through 4, which are described below.

NOTE: If the immigration documents for statuses 1 through 4 are dated August 22, 1996, or after, but the legal date of entry was before that date, please also send in the document that shows the earlier date. If eligible for the Program, not having proof of entry before August 22, 1996, will not disqualify you.

1. An alien lawfully admitted for permanent residence under the Immigration and Nationality Act (INA) must submit a copy of INS form I-551; or an I-94 with a current I-551 stamp, or an I-551 stamp on a foreign pass; ***or***
2. An alien granted conditional entry pursuant to Section 203(a)(7) of the INA must send a copy of INS form I-94 with a stamp showing admission under 203(a)7 of the INA or INS form I-688B showing admission under "274a.12(a)(3)"; ***or***

Citizenship and Immigration Information

3. An alien paroled into the U.S. under Section 212(d)(5) of the INA for at least one year must send a copy of INS form I-94 showing admission for at least one year under section 212(d)(5) of the INA; or a notice, or court order from an immigration Judge granting parole for at least one year; ***or***
4. An alien with the appropriate immigration status who (or whose child or parent) has been battered or subjected to extreme cruelty in the U.S. and there is a substantial connection between the battery or extreme cruelty and the need for the benefits, and who no longer resides in the household of the batterer, must send a copy of the approved INS form I-130 or approved INS form 360 petition filed under the Violence Against Women Act (VAWA), or INS form I-797 indicating filing of the I-360 petition.

The following group of immigrants do not have restrictions on the date of entry:

5. An alien granted asylum under Section 208 of the INA must send a copy of INS form I-94 showing grant of asylum under section 208 of the INA; or INS form I-688B under section "274a.12(a)(5)"; or INS form I-766 with the code "05," or a grant letter from the asylum office of the INS; or an order from an Immigration Judge granting asylum; ***or***
6. A refugee admitted to the U.S. under Section 207 of the INA must send a copy of form I-94 showing admission as a Refugee under section 207 of the INA, or INS form I-688B under section 274a.12(a)(3) or INS form I-766 with the code "A3," or INS form I-551 with the code "RE" or INS form I-571, Refugee Travel Document; ***or***

(continued on next page)

7. An alien whose deportation is being withheld by order of an immigration judge under section 243(h) of the INA as in effect prior to April 1, 1997, or whose removal is being withheld under Section 241(b)(3) of the INA must send a copy of INS form I-688B with the code "274a.12(a)(10)," or INS form I-766 with the code "A10"; ***or***
8. An alien who is a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980 must send a copy of INS form I-551 with the codes CU6, CU7 or CH6; or a current I-551 stamp with the codes CU6 or CU7 on the INS form I-94; or a current I-551 stamp on a foreign passport with the codes CU6 or CU7; or an INS form I-94 with a stamp showing parole as a "Cuban/Haitian entrant" under section 212(d)(50) of the INA; ***or***
9. Qualified aliens lawfully residing in any state who are honorably discharged veterans who fulfill minimum active duty service requirements, or who are on non-training active duty in the U.S. armed forces must send a copy of DD form 214 or a copy of their military identification card if on active duty, or a copy of current military orders; ***or***
10. The spouse or unmarried dependent or the unmarried surviving spouse whose marriage satisfies the requirements of 38 U.S.C. 1304 of those veterans or persons on active duty described in the previous sentence must send a copy of a current military identification card to establish marital relationship to the veteran, or parent-child relationship to the veteran; ***or***
11. An Amerasian immigrant admitted to the U.S. pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 as described in Section 1612(a)(2)(A)(1)(V) of Title 8 of the United States Code must send a copy of INS form I-551 with the code AM6, AM7, or AM8. A current temporary I-551 stamp in a foreign passport with the code AM1, AM2 or AM3; or INS form I-94 with the codes AM1, AM2 or AM3.

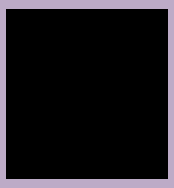
Citizenship and Immigration Information

When must documents be submitted?

- All applicants have two months from the date of enrollment to provide proof of citizenship and/or immigration status documentation.

If a member is disenrolled because you did not submit the necessary documents, you can reapply again but you must submit copies of the birth certificate, certificate of naturalization, U.S. passport or INS documents at the time you reapply.

If you have questions about acceptable documents, ***call toll-free 1-800-880-5305***.



You can visit our Web site at ***www.healthyfamilies.ca.gov***

Other Program Information

Reporting a Change of Address

You must notify the Healthy Families Program within 30 days if you have a change of address, because your family members may need to transfer to a different health plan. It is your responsibility to be sure Healthy Families has your correct billing address and the correct address of your family members enrolled in the Program.

To report a change, ***call toll-free 1-866-848-9166***. You can call between 8 a.m. and 8 p.m., Monday through Friday, and Saturday from 8 a.m. to 5 p.m. Or write to:

Healthy Families Program
Attn: Address Change
P.O. Box 138005
Sacramento, CA 95813-8005

Changes in Income and Family Size

If my income or family size changes, do I submit new information?

You do not have to submit new information until the Annual Eligibility Review (AER), or when you add a person. Once eligibility is established, your children will be covered for a 12-month period (one year), unless a person enrolled in Healthy Families turns 19, is disenrolled due to non-payment or you request disenrollment.

If your family income decreases before AER and you would like us to re-evaluate your child's eligibility or your premiums, ***call toll-free 1-866-848-9166.***

Changes in your income or family size may affect your children's future eligibility. If your income falls below Healthy Families guidelines, your children may be eligible for free health coverage through the Medi-Cal Program.

Other Program Information

Disenrollments from the Healthy Families Program

If any of the following occurs, Healthy Families coverage will end. Your child will be disenrolled if:

- You do not pay your family's monthly premium for two consecutive months; ***or***
- Healthy Families finds that your child does not qualify during the Annual Eligibility Review; ***or***
- You do not provide the information needed for your children's Annual Eligibility Review; ***or***
- Your child qualified for no-cost Medi-Cal, ***or***
- Your child reaches 19 years of age; ***or***
- You write to Healthy Families asking to end enrollment; ***or***
- Healthy Families finds that you made false declarations about your child's eligibility; ***or***
- You did not return the Annual Eligibility Review Form by the due date, before the end of the anniversary month; ***or***
- You do not provide documentation requested, birth certificates or INS documents when due.

You will receive a written disenrollment notice before the health, dental and vision coverage of a member ends and that person is disenrolled from the Program.

The notice gives the reason and the effective date of disenrollment. If you disagree with the decision, see the *Appeals Process Section* on *page 32* in this Handbook.

How do I re-enroll my child in Healthy Families?

If your child is disenrolled, you must complete the Re-enrollment Form and mail it in within 60 days.

If you are re-applying within one year of the child's disenrollment date, you will be required to pay all past due and current premiums in order to re-enroll your child.

For information about any required payment for re-enrollment or to request a Re-Enrollment Form, please **call 1-866-848-9166**. You will need to send in with your completed re-enrollment form, proof of income and deductions, and premium payment.

To re-enroll after 60 days from the disenrollment date, you will need to reapply using the Healthy Families Application.

Other Program Information

Family Contribution Sponsor

A Family Contribution Sponsor is a person or entity who is registered with the Managed Risk Medical Insurance Board (MRMIB) and who pays a family's premiums on behalf of an applicant for any 12 months in the program. For more information about Sponsorship and to register as a sponsor, go to the Healthy Families web site, www.healthyfamilies.ca.gov.

Health Insurance Portability and Accountability Act (HIPAA) Notices

The Healthy Families Program is considered "creditable" coverage under HIPAA for purposes of qualifying your child for other health insurance coverage after you leave Healthy Families. This is important when you have a pre-existing health condition, and you are moving from Healthy Families to a new health insurance plan. In these cases, if your child has had 18 months of coverage in Healthy Families, it may cancel any pre-existing condition exclusions or waiting periods of the new health insurance plan. Within 10 days of disenrollment, the Healthy Families Program will send you a HIPAA notice. This notice lists your child's eligible months of creditable coverage while enrolled in the Program.

If you have questions, ***call toll-free 1-866-848-9166***, between 8 a.m. and 8 p.m., Monday through Friday, and Saturday from 8 a.m. to 5 p.m.

Other Program Information

Transfers

You can request a transfer for your child from one health or dental plan to another. All transfer requests must be in writing. You can fax your request or mail it. Be sure to write your Family Member Number on each document you send. Transfers will be allowed if:

- You request a health plan transfer, one time for any reason, within the first three months from the original effective date of coverage in the Program; ***or***
- You request a dental plan transfer, one time for any reason, within the first three months from the original effective date of coverage in the Program; ***or***
- You request a health or dental plan transfer, one time for any reason, within the first 30 days of the effective date of coverage in a new plan following Open Enrollment; ***or***
- Your child moves out of the area served by the chosen insurance plan and at least one other participating insurance plan serves the area in which the family or child lives; ***or***
- You or the participating insurance plan request in writing because the family or member and insurance plan cannot establish a good relationship; ***and*** the Executive Director of the Managed Risk Medical Insurance Board determines that the transfer is in the best interest of the child and the Program; ***or***
- The Board does not renew the contract with the participating insurance plan in which the family or member is enrolled, or the contract is canceled.

NOTE: All transfer requests must be for one of the reasons in this list. If your reason for requesting a transfer is not one of the above, you must wait for the annual Open Enrollment.

Health plan transfers will take effect within 40 days from the date the transfer is approved. Subscribers in inpatient facilities at the time of the scheduled date of transfer will be transferred to the new plans on the first day of the month after completion of their inpatient stay.

(continued on next page)

Other Program Information

When transfers between health plans occur, the monthly premium will be recalculated. The new premium may be higher, depending on the new plan chosen. Healthy Families will notify the applicant in writing if and when there is a change in the monthly premium amount. A plan transfer will not change the premium amount paid by a sponsor.

Mail your transfer request to:

Healthy Families Program
Attn: Transfer Department
P.O. Box 138005
Sacramento, CA 95813-8005

or fax your transfer request to:
1-866-848-4974.

Program Transfers

If the Program learns that your child no longer resides in an area served by your chosen health, dental, and vision plans, Healthy Families will notify you in writing to choose new plans in your new area of residence.

If you do not choose new plans within 30 days from the date of the written notice, Healthy Families will enroll your child in the Community Provider Plan in your new area.

Healthy Families will choose the dental plan by alternate assignment if there is more than one dental plan in your area.

Annual Open Enrollment Period

Each year you can choose a new health and dental insurance plan for your family. This process is called "Open Enrollment." It is held from April 15 to May 31 of each year.

Healthy Families will mail you information in early April. This information will describe the Open Enrollment process.

If you choose new insurance plans during Open Enrollment, all enrolled persons in the household will be transferred to the new insurance plans. The transfer will be effective on July 1.

Other Program Information

Annual Eligibility Review

Each year you will be asked to confirm your child's qualifications for the Healthy Families Program. We will notify you by mail of the Annual Eligibility Review process (AER).

You will receive a notice about 60 calendar days before the end of your family's anniversary date in the Healthy Families Program. We must receive your AER form and documentation by the time stated on the packet. If each enrolled child continues to qualify for the Program, coverage will continue for another 12 months.

What if my child does not requalify during AER?

If your child does not requalify for the Program during AER because your household income is below the Program's guidelines, your child will receive two months of continued eligibility in Healthy Families. This eligibility bridging period will allow Healthy Families to forward your AER forms to Medi-Cal for eligibility determination, unless you check the **"I DO NOT WANT Medi-Cal"** box. Under the Medi-Cal Program, children receive free health coverage.

How many Annual Eligibility Reviews will I have when I enroll more family members in Healthy Families?

The eligibility review date for your child will be 12 months from the date the last person is enrolled.

In other words, each time you enroll a new child in the Program, you requalify all your children who are enrolled in Healthy Families for another 12 months.

How do I enroll more children into the Healthy Families Program?

To enroll a baby or child, ***call toll-free 1-866-848-9166*** to request an Add a Person form. You can call between 8 a.m. and 8 p.m., Monday through Friday, and Saturday from 8 a.m. to 5 p.m.

If the baby or child does not qualify for Healthy Families, we will forward the Add a Person Form to the Department of Social Services in your county to determine Medi-Cal eligibility for free health coverage, if you give us authorization.

Other Program Information

Appeals Process

What types of decisions can I appeal?

You can file an appeal if you believe an eligibility, effective date of coverage, or disenrollment decision was made in violation of the rules. The appeals process consists of three separate levels of review:

First level appeal: This appeal must be filed within 60 days from the date of the decision letter. This process requires a written appeal from the applicant or authorized representative. The issue addressed by this type of appeal must be an issue of eligibility (denial), disenrollment, or effective date of coverage in the Program.

Healthy Families will review and respond to your appeal in writing within 30 days. Send your first level appeal to:

Healthy Families Program
Attn: Appeals Department
P.O. Box 138005
Sacramento, CA 95813-8005

The postmark on the envelope or the date a fax is sent will be considered the filing date. Appeals filed after the deadline will be treated as program review requests.

To file an appeal complete the form included with the decision letter.

Whether you use our form or write your own letter, you must do the following when you file your request for a first level appeal:

- Send us a copy of the written notice or tell us which decision you disagree with; **and**
- Explain why you think our decision is wrong. If you think we made a mistake about the facts of your case, please tell us. If you think we violated a program rule, such as a law or regulation or other written policy, please tell us; **and**
- Tell us how you want this appeal to be resolved (what you want us to do); **and**
- Give us any other information you want us to consider; **and**
- Be sure to include your Family Member Number on each document you send to the Program.

Other Program Information

Second level appeal: If you disagree with the Healthy Families decision of the first level appeal, you can file a second level appeal with the Executive Director of the Managed Risk Medical Insurance Board (MRMIB), the agency that administers the Program. File your second level appeal within 30 days from the date of the decision letter. Second level appeals are written appeals from an applicant or authorized representative regarding the decision rendered on the first level appeal. Mail your second level appeal to:

Executive Director
Managed Risk Medical Insurance Board (MRMIB)
P.O. Box 2769
Sacramento, CA 95812-2769

You may also fax your appeal to (916) 327-6560.

Your appeal will be reviewed and a response will be sent in writing. If you disagree with the decision of the MRMIB Executive Director, you have the right to request an administrative hearing.

Third level administrative hearing: You will have 30 days from the date of the MRMIB Executive Director's decision letter to request an administrative hearing. The notice from MRMIB will contain all the information that you will need to file a request for an administrative hearing. You will be notified in writing of the date, time and place of the administrative hearing.

In addition to the above appeals process, the Program has discretion to provide "program reviews," which are informal reviews of issues, such as billing questions, account balances and other complaints and questions, that are not subject to a formal appeal or do not meet the appeal deadlines.

Can I request continued coverage for my child until a decision on my appeal is made?

If you appeal the disenrollment decision before the disenrollment date, your child will receive Continued Enrollment (CE). CE means that your child will continue to be enrolled in Healthy Families until a decision is made in your first level appeal. Healthy Families must receive your written request for CE before the end of the month in which the disenrollment will occur. Healthy Families cannot review appeals over the phone. You can use the Continued Enrollment Form that is included with the disenrollment notice to file your appeal or write us a letter. You can fax your appeal to 1-866-848-4974 ATTN: Review Unit, or mail to:

Healthy Families Program
Attn: Review Unit
P.O. Box 138005
Sacramento, CA 95813-8005

Other Program Information

Can I appeal a health, dental or vision plan decision?

If you are unhappy with something your health, dental or vision plan did (or did not do), you must resolve your problems with the plan according to its established policies and procedures. Your child will not be dropped from the plan or suffer a penalty if you do this. The procedures are listed in the Evidence of Coverage (EOC) or Certificate of Insurance (COI) Booklet. You will receive these booklets from your child's health, dental and vision plans. You may review these documents prior to selecting an insurance plan. Call the plans directly and ask for a copy.

If you are unable to resolve your dispute with the plans and your insurance plan is licensed by the state, contact the state government agency, Department of Managed Health Care or Department of Insurance which licenses the insurance plan. The number is in the EOC or COI Booklet.

NOTE: Enrollment in many health insurance plans requires that you waive your right to a jury trial and agree to have some or all claims or disagreements decided by binding arbitration. This requirement may include malpractice issues. See pages 87-96 in this handbook for information on which plans require binding arbitration.

The Americans with Disabilities Act of 1990

The contractor utilizes the California Relay Service to communicate with hearing impaired individuals as needed. All services are provided at no cost to the requester. The toll free number is 1-800-735-2929. Section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall, on the basis of disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance.

California Government Code Section 11135 prohibits discrimination in a program or activity funded directly by the state or that receives financial assistance from the state on the basis of ethnic group identification, religion, age, sex, color or disability.

California Government Code Section 11136 requires state agencies, as described above, to notify a contractor of whom they have reasonable cause to believe has violated the provisions of Section 11135 or any regulation adopted to implement such section.

Other Program Information

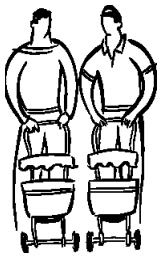
After considering all evidence, the Executive Director of the Managed Risk Medical Insurance Board may request a hearing to determine whether a violation has occurred.

The Americans with Disabilities Act of 1990 (ADA) prohibits the Managed Risk Medical Insurance Board and its contractors from discriminating on the basis of disability. The Act protects its applicants and enrollees with disabilities in program services. It also requires the Board to make reasonable accommodations to applicants and enrollees that do not pose undue hardship on the Board.

The Managed Risk Medical Insurance Board has designated an ADA Coordinator. This person will carry out its responsibilities under the Act. You may have questions or concerns about ADA compliance by the Board or its contractors. If so, contact the Coordinator at:

ADA Coordinator
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695

The hearing impaired can contact the ADA Coordinator through the California Relay Service at 1-800-735-2929.



Charts to Determine Monthly Premiums

How do I determine my monthly premium?

To determine the monthly insurance premium for the children in your family, you must first determine whether your monthly income falls in category A or B. You will need the following information:

- Number of family members living in the household.
- Net monthly income (after any deductions allowed, as listed below).

Deductions Allowed

If both parents work and pay child care, or pay or receive child support and/or alimony, deduct the following expenses from your gross monthly income:

- If you pay court-ordered child support or alimony, deduct the amount you pay from your gross income.
- If you receive court-ordered child support or alimony, deduct $50.
- For each working parent, deduct up to $90 for work-related expenses.
- For each person receiving State Disability Compensation, deduct up to $90.
- Subtract the child care expenses you pay for each child or dependent from your gross monthly income to determine your net monthly income. The maximum deductible amounts allowed for each child and disabled dependent are:

Child **under** the age of 2 =	$200
Child 2 years old and **over** =	$175
Disabled dependent, any age =	$175

NOTE: Child care expenses are deducted only if both parents work.

Determining your Income and Premium

To determine net income:

- First, figure out your gross monthly income. Add up the gross amounts on your pay stubs.
- Second, add up your total monthly deductions allowed by the Program.
- Last, subtract your deductions from your gross income.
- The difference is your monthly net income.

To determine your child's premium:

- On the chart below, locate your family size and net income column to find your income category, A or B.
- Turn to *page 43*, to the *Insurance Plan by County and Premium* section.
- Find your county of residence and turn to that page.
- Choose your insurance plan, and find your insurance premium category, A or B.

Family Size (Number of Persons)	Category A Monthly Income	Category B Monthly Income
1	$750.00 - $1,123.00	$1,123.01 - $1,871.00
2	$1,011.00 - $1,515.00	$1,515.01 - $2,525.00
3	$1,273.00 - $1,908.00	$1,908.01 - $3,180.00
4	$1,535.00 - $2,300.00	$2,300.01 - $3,834.00
5	$1,796.00 - $2,693.00	$2,693.01 - $4,488.00
6	$2,058.00 - $3,085.00	$3,085.01 - $5,142.00
7	$2,320.00 - $3,478.00	$3,478.01 - $5,796.00
8	$2,581.00 - $3,870.00	$3,870.01 - $6,450.00
9	$2,843.00 - $4,263.00	$4,263.01 - $7,105.00
10	$3,105.00 - $4,655.00	$4,655.01 - $7,759.00
	For more than **10** persons, add the amount listed below for each additional child:	
	$263.00 - $393.00	$394.00 - $655.00

Healthy Families Program Privacy Notification

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

When you apply for the Healthy Families Program, the information you provide in the application is reviewed by a private contractor hired by the State of California to assist in the administration of the Program. The contractor evaluates whether your family may be eligible for the Healthy Families and Medi-Cal programs. The contractor and the State will use this information for administration and evaluation of the program and for necessary purposes authorized by law.

If members of your family are determined eligible for Healthy Families, the contractor will then forward your information to the health insurance plan and provider that you select, so that your family can begin to receive health insurance coverage under that plan.

If members of your family appear to be eligible for Medi-Cal and you do not indicate that you do not want Medi-Cal, then the information you supply with your application will be forwarded to the Department of Social Services where you live so they can determine if your child is eligible for the Medi-Cal program.
Uses and disclosures that are not part of the operations of the program will only be made with the applicant's written authorization, which can also be later revoked through a letter from the applicant.

Your rights regarding how your personal information is used

You have the right to request the Healthy Families Program to restrict the use of your personal information. However, the program may not agree to restrictions if it would prevent its normal operations. You also have the right to get a copy, or request to change the personal information you provided to the Healthy Families Program as long as the program retains such information. You have the right to get an accounting of how your personal information was disclosed, other than the use of your information by the Healthy Families Program to carry out the operations of the program.

The Healthy Families Program is required by law to maintain the privacy of the information you provide in your application, to

Healthy Families Program Privacy Notification

inform you of its privacy practices and to abide by the terms of this notice, which became effective July 1, 2002. Healthy Families may revise the privacy practices described here, and will notify program subscribers in updated program handbooks or through direct mailed notices within 60 days of such revision. You may complain to the Healthy Families Program if you believe your privacy rights have been violated by contacting:

Privacy Officer
Healthy Families Program
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695

This evaluation may compare the income information you provide on your application with other State databases containing income and tax information on your family and household. The Healthy Families Program will not share the application information with State, local or federal tax authorities and agencies.